Eligibility Response Options:

Draft of EE TAG Recomendations

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1 Requester Permission Business Rules

Providers are not allowed to know any and all of a client's eligibility. Each DSHS Administration must determine which providers have access to what eligibility data. Not all entries in the provider file are for healthcare providers, e.g., case managers, transmission intermediaries. Requesters could also be state staff.

We could create a permission file which can be configured to determine whether a requester (who sends a 270-eligibility request) is permitted to get the answer requested. It could be similar to (or a subset of) the MMIS provider master file.

Each DSHS Administration would register all permitted requesters in the permission file F—and configure the following options to determine the requester's type of access. In this way, the system will know that the requester is approved or contracted by the Administration to have access to specified programs' information.

Each Requester must be:

Criteria	**MMIS enforces**	**MHD enforces**	**DDD enforces**
An Administration-approved provider of relevant services		Y	
Registered by Administraction for eligibility requests, that is, Active in the permission file	Y		
Allowed access to the program(s) being inquired about			
A provider type proper to the coverage type			
A provider type proper to the service type			
Under the maximum number of requests per day per requester set up for each program			

The response options discussed below assume that the requester has passed whatever level of security is decided upon above.

2 Response Options

There are three types of HIPAA eligibility requests:

- "General" is just about member level data

- "Categorical" is about a type of service for a client
- "Specific/Explicit" is about a procedure for a client

Request Type	Response Type	Reference
General	Always send eligibility for Medicaid, demographics, DSHS elig. (scope of care, managed care, etc.), TPL	Program Level Information (section 2.1.2)
Categorical	If provider has permission, send same as "General".	Program Level Information (section 2.1.2)
Specific & we DON'T have the cafeteria style benefits	If provider has permission, send same as "General".	Program Level Information (section 2.1.2)
Specific & we have the cafeteria style benefits	If provider has permission, send same as "Categorical".	Specific Authorized Procedures, plus Program Level Information (section 2.1.2)

2.1 General Request

In a "General" eligibility request, the requester is asking whether a client is covered by Medicaid.

270-Request Contains:	Required/Optional	HIPAA Data Element
Requester	R	Loop 2100B NM109
Type of Request = General	R	Loop 2110C EQ01 = "30"
Client's PIC	R	Loop 2100C NM109
Client Name	O	Loop 2100C NM1
Client DOB	O	Compare with plan age range
Relevant Date (defaults to current)	O	Loop 2100C or 2110C DTP

2.1.1 Minimum Response

Every payer must support a "General Request", which merely identifies the patient/client. The response can be as little as "Yes (or No), this person is in our database and has some kind of eligibility for the relevant date(s)", without saying what kind of eligibility.

271-Response Contains:

Requester
Client's PIC
Relevant date (defaults to current)
Type of Request = 30-General
Status: 1-Active / 6-Inactive

In addition, the Final Rule says we must support electronically at least what we're doing now (electronic or paper or phone). This means we should at least send back what is currently provided over the phone.

We don't have to send what is provided on the ID Card data, but we may choose to send it, as confirmation to the requesters. But not all ID Card data is stored in MMIS. We originally thought that we must include all ID card data, since the providers are getting this data now. But Stuart Beaton thinks the ID card does not count as an eligibility response. This is retained in case it becomes an open issue again.

Fields on ACES ID Card (MAID) (card message file)	**In MMIS?**
Eligibility begin/end dates	Y
Medicaid coverage group	Y
PIC	Y
Insurance carrier code (TPL: other payer ID)	Y
Medicare coverage indic	Y
HMO plan code or "PCCM"	Y
Detox elig indic	Y, if PROGRAM-CODE = "W"
Restriction indic if one prov	Y
Hospice indic	Y, if RECIP-EXCEP-INDIC="D"
DD indic	Y, if RECIP-EXCEP-INDIC="E"
HIC, if Medicare	Y
HOH name & address (Subscriber)	N
Program	Y: program/match/medical-codes
Scope of care	Y: restricted, DD, hospice (elig screen 5)
Text comment = program	Y
RSN/PCCM (case mgr) phone & name	Y: PCOP-BILLING-PROV when PCOP-TYPE="P"-PCCM

Address of CSO	N: will build FE lookup via CSO#
CSO# & AUID (ACES unit #)	Y

2.1.2 Program Level Information

We will respond with much more than the minumum.

The more of the (optional) coverage information we can supply, the fewer phone calls and complaining providers. Here's a first draft of what we could provide for each type of HIPAA eligibility request. This is a working draft of a proposal for discussion of how we will respond to eligibility queries.

The 271-Eligibility Response will contain the following information. In the first column, "A" indicates the data will be sent if we have it, and "C" indicates that whether we send it can be configured for each program.

A or C	**Description**	**HIPAA Data Elements (EB01="IL"-insured or subscriber)**	**MMIS Fields**
A	Requesto'sr ID	Loop 2100B NM109	(save what comes in on 270)
A	Client Last Name	Loop 2100C NM103	RECIP-ELIG-FILE: RECIP-LAST-NAME
A	Client First Name	Loop 2100C NM104	RECIP-ELIG-FILE: RECIP-FIRST-NAME
A	Client Middle Name or Initial	Loop 2100C NM105	RECIP-ELIG-FILE: RECIP-MIDDLE-INIT
C	* Verified Client PIC	Loop 2100C NM109	RECIP-ELIG-FILE: RECIP-IDENT-NUMBER
C	ACES ID	Loop 2100C REF "1W"	RECIP-ELIG-FILE: RECIP-CLIENT-ID
C	ACES AUID	Loop 2100C REF "3H"	RECIP-ELIG-FILE: RECIP-AU-NUMBER?
C	HIC (Medicare SSN+)	Loop 2100C REF "F6"	?
C	Client SSN (only return if submitted)	Loop 2100C "SY" REF02	RECIP-ELIG-FILE: SOC-SEC-NUMBER (not req'd & may not be correct)
C	Client Address, Street 1	Loop 2100C N301	RECIP-ELIG-FILE: RECIP-ADDR-LINE-1
C	Client Address, Street 2	Loop 2100C N302	RECIP-ELIG-FILE: RECIP-ADDR-LINE-2
C	Client Address, Street 3	Loop 2100C N302	RECIP-ELIG-FILE: RECIP-ADDR-LINE-3
C	Client Address, City	Loop 2100C N401	RECIP-ELIG-FILE: CITY
C	Client Address, State	Loop 2100C N402	
C	Client Address, Zip	Loop 2100C N403	RECIP-ELIG-FILE: RECIP-ZIP-CODE
C	Client Phone	Loop 2100C PER	RECIP-ELIG-FILE: RECIP-PHONE-NUMBER
A	Case Number	Loop 2100C "3H" REF02	RECIP-ELIG-FILE: RECIP-CASE-NUMBER
A	Client DOB	Loop 2100C DMG02	RECIP-ELIG-FILE: RECIP-DATE-OF-BIRTH;

			Compared with plan age range
A	Client Gender	Loop 2100C DMG03	RECIP-ELIG-FILE: RECIP-SEX-CODE
A	* Client Coverage Dates	Loop 2110C "307" DTP	RECIP-ELIG-FILE: RECIP-ELIG-BEG-DATE and RECIP-ELIG-END-DATE
A	HMO Month of Coverage	Loop 2110C "307" DTP	RECIP-ELIG-FILE: if requested date is within any of PCOP-BEGIN-DATE and PCOP-END-DATE date ranges
A	Eligibility Status: see codes IG p. 296-297	Loop 2110C EB01, EB02, EB06	Cross-ref based on program code, age, HMO, etc.
A	* **Coverage Information**: Administration's Program	Loop 2110C EB05 (plan coverage description)	RECIP-ELIG-FILE: PROGRAM-CODE; map codes (only one per client in MMIS, more in ACES; need more in MMIS)
A	* **Coverage Information**: Accounting Code	Loop 2110C EB05 (plan coverage description)	RECIP-ELIG-FILE: MATCH-CODE
A	* **Coverage Information**: Eligibility Code	Loop 2110C EB05 (plan coverage description)	RECIP-ELIG-FILE: MEDICAL-CODE
A	* **Coverage Information**: Scope of Care (MAID) (CN, MN, LCP-MNP, GAU, MI)	Loop 2110C EB05 (plan coverage description)	RECIP-ELIG-FILE: PROGRAM-CODE RECIP-ELIG-FILE: MATCH-CODE RECIP-ELIG-FILE: MEDICAL-CODE
A	* **Coverage Information**: Managed Care PCOP (RSN, HMO)	Loop 2110C EB05 (plan coverage description)	RECIP-ELIG-FILE: PROVIDER-NUM
A	Contracted Service Provider Name & ID	Loop 2120C "13" NM103,4,9	RECIP-ELIG-FILE: PROV-NUMBER PROV-FILE: PROV-NAME
A	* CSO # (local client services office)	Loop 2120C NM01="GP" with NM108 = "FA"	CSO-OF-RESIDENCE
A	Co-Pay	Loop 2110C EB07 where EB01="B"-Co-Payment	Not currently captured in MMIS
A	Spend Down Amount [policy issue]	Loop 2110C EB07 where EB01="Y"-Spend Down	Not in MMIS, just ACES; get it?
A	* PCCM name (primary care case mgr)	Loop 2120C "GP" NM103,4,5, 9	PCOP-BILLING-PROV, when PCOP-TYPE="P"-PCCM, links to prov file
A	* PCCM phone	Loop 2120C PER	PCOP-BILLING-PROV, when PCOP-TYPE="P"-PCCM, links to prov file

A	* CSO address	Loop 2120C N3, N4	will be handled by FE lookup
A	* DD indicator	Another EB for Plan = DDD & EB04="DB"-disability benefits	RECIP-EXCEP-INDIC="E"
A	* Restriction to one provider	EB01="N"-restrict to following prov with prov-num in Loop 2120C "13" NM109	RECIP-EXCEP-INDIC + PROVIDER-NUM
A	* Detox eligibility indicator	EB03="AI"-substance abuse	PROGRAM-CODE = "W"
A	* Hospice indicator	EB03="45"-hospice	RECIP-EXCEP-INDIC="D"
A	* HOH, guardian name	Loop 2110C "LR" NM103,4,5	
A	* Text comment	Loop 2110C MSG	"This is the client's eligibility as of this date, based on information available at this time."
	TPL Information (currently sent via MEV system) (Store it if comes in on 270?)	**For TPL info, use two separate EB Loops with EB01="R"-other payer: one with NM101="IL" - subscriber, one with NM101="PR" - payer**	**RECIP-ELIG-FILE: (TPL fields)**
A	Policy Number	Loop 2110C "IG" REF in both TPL EB loops	POL-CERT-NUM
A	Subscriber SSN	Subscr. Loop 2120C "IL" NM109 with NM108 = "34"	SSN-OF-INSURED
A	* Subscriber Member Number (if Medicare, HIC contains SSN)	Subscr. Loop 2110C "IL" NM109 with NM108 = "MI"	MEMBERSHIP-NUMBER (ACES currently using pol-cert-num for this, instead)
A	* Subscriber Name	Subscr. Loop 2120C "IL" NM103,4,5	NAME-OF-INSURED
A	Subscriber Group Number	Subscr. Loop 2110 C "6P" REF02	GROUP-NUMBER
A	Group Name	Subscr. Loop 2110C "6P" REF03	POLICYHOLDER-NAME=group name if group-number is present
A	Employer Name	Subscr. Loop 2120C "36"-employer NM103	POLICYHOLDER-NAME= employer name if group-number is not present
A	Coverage Begin/End Date	Loop 2110C "307" DTP in both TPL EB loops	COV-BEGIN-DATE & COV-END-DATE
A	* Other Payer Name (e.g., Medicare)	Payer Loop 2120C "PR" NM103	CARRIER-NAME
A	* Other Payer ID	Payer Loop 2120C "PR" NM109	CARRIER-ID
A	Non-Covered Services	Don't want to send other payer's benefits	TPL-CODES
A	Non-covered procedures (local codes)	Don't want to send other payer's benefits	TPL-CODES

	MMIS: autom exclude by client+proc, stored prior based on TPL plan. Same for diagnoses		
A	Excluded provider types: taxonomy MMIS: autom exclude	Don't want to send other payer's benefits	PRE-PROV-TYPE-IND & PRE-PROV-TYPE-CD
A	Pay & chase (use?)	Don't want to send other payer's benefits	POST-PROV-TYPE-IND & POST-PROV-TYPE-CD

* These are the ID Card fields.

2.1.3 TPL Information

The MAA COB personnel send a list of clients to the managed care providers whom they believe to have third party coverage. The managed care provider confirms whether or not the person has third party coverage and sends the confirmation back to the MMIS COB office. If the client does have third party coverage, they are taken out of the Healthy Options plan and put into fee-for-service coverage. (Norma and Carmen from TPL group said this data is verified, but EE TAG decided not to send TPL benefit level information.)

2.1.4 Coverage Information

There is only one (free-text) field in HIPAA 271 to put a plan/program coverage description. Local codes (in MMIS or ACES) for program-code, match-code, medical-code, etc. need to be mapped to something the providers understand. Doing this will take a team of people who know ACES and MMIS and all the various coverage options.

ACES already does business rules to determine what to print on the MAID. We can add a field to the extract file to hold the program name as it appears on the MAID. This would need to be stored with each span, since it can change. This would be a short name or acronym, which could be converted to a longer descriptive name for the 271 using a lookup file.

We need to be able to send more than one code/plan/program per client.

2.2 Categorical Request

In a "Categorical" request the requester is asking whether a client is covered for a certain type of service. We could respond with the relevant program eligibility.

[Same as 'General', plus …]

270-Request Contains:	HIPAA Data Element
Specific Provider Type –or--	Loop 2100C PRV03
Specific Service Type	Loop 2110D EQ01 (not "30") or Loop 2110D EQ03

MMIS has decided not to support this. Currently Sandy Mitchell, Provider Relations can compare the PROCEDURE-MASTER provider type and type of service to the PROVIDER-FILE provider type and category of service.

2.2.1 Provider Types

To compare incoming provider types, the process will search the client's program(s) to find covered provider types.

2.2.2 Service Types

To compare incoming service types, the process will search the client's program(s) to find all covered service types. We would need to be able to map/use HIPAA service types for each program.

HIPAA service types must be mapped to DSHS provider types & programs. We must decide which service types to support, besides the minimum "030"-generic request. Following are the HIPAA service types (I.G., pp. 221 – 226):

1 Medical Care
2 Surgical
3 Consultation
4 Diagnostic X-Ray
5 Diagnostic Lab
6 Radiation Therapy
7 Anesthesia
8 Surgical Assistance
52 Hospital - Emergency Medical
53 Hospital - Ambulatory Surgical
54 Long Term Care
55 Major Medical
56 Medically Related Transportation
57 Air Transportation
58 Cabulance
59 Licensed Ambulance
98 Professional (Physician) Visit - Office
99 Professional (Physician) Visit - Inpatient
A0 Professional (Physician) Visit – Outpatient
A1 Professional (Physician) Visit - Nursing Home
A2 Professional (Physician) Visit - Skilled Nursing Facility
A3 Professional (Physician) Visit - Home
A4 Psychiatric
A6 Psychotherapy

9 Other Medical
10 Blood Charges
11 Used Durable Medical Equipment
12 Durable Medical Equipment Purchase
13 Ambulatory Service Center Facility
14 Renal Supplies in the Home
15 Alternate Method Dialysis
16 Chronic Renal Disease (CRD) Equipment
17 Pre-Admission Testing
18 Durable Medical Equipment Rental
19 Pneumonia Vaccine
20 Second Surgical Opinion
21 Third Surgical Opinion
22 Social Work
23 Diagnostic Dental
24 Periodontics
25 Restorative
26 Endodontics
27 Maxillofacial Prosthetics
28 Adjunctive Dental Services
32 Plan Waiting Period
33 Chiropractic
34 Chiropractic Office Visits
35 Dental Care
36 Dental Crowns
37 Dental Accident
38 Orthodontics
39 Prosthodontics
40 Oral Surgery
41 Routine (Preventive) Dental
42 Home Health Care
43 Home Health Prescriptions
44 Home Health Visits
45 Hospice
46 Respite Care
47 Hospital
48 Hospital - Inpatient
60 General Benefits
61 In-vitro Fertilization
62 MRI/CAT Scan
63 Donor Procedures
64 Acupuncture
65 Newborn Care
66 Pathology
67 Smoking Cessation
68 Well Baby Care
69 Maternity
70 Transplants
71 Audiology Exam
72 Inhalation Therapy
73 Diagnostic Medical
74 Private Duty Nursing
75 Prosthetic Device
76 Dialysis
77 Otological Exam
78 Chemotherapy
79 Allergy Testing
80 Immunizations
81 Routine Physical
82 Family Planning
83 Infertility
84 Abortion
85 AIDS
86 Emergency Services
87 Cancer
88 Pharmacy
89 Free Standing Prescription Drug
90 Mail Order Prescription Drug
91 Brand Name Prescription Drug
92 Generic Prescription Drug
93 Podiatry
94 Podiatry - Office Visits
A7 Psychiatric - Inpatient
A8 Psychiatric - Outpatient
A9 Rehabilitation
AA Rehabilitation - Room and Board
AB Rehabilitation - Inpatient
AC Rehabilitation - Outpatient
AD Occupational Therapy
AE Physical Medicine
AF Speech Therapy
AG Skilled Nursing Care
AH Skilled Nursing Care - Room and Board
AI Substance Abuse
AJ Alcoholism
AK Drug Addiction
AL Vision (Optometry)
AM Frames
AN Routine Exam
AO Lenses
AQ Nonmedically Necessary Physical
AR Experimental Drug Therapy
BA Independent Medical Evaluation
BB Partial Hospitalization (Psychiatric)
BC Day Care (Psychiatric)
BD Cognitive Therapy
BE Massage Therapy
BF Pulmonary Rehabilitation
BG Cardiac Rehabilitation
BH Pediatric
BI Nursery
BJ Skin
BK Orthopedic
BL Cardiac
BM Lymphatic
BN Gastrointestinal
BP Endocrine
BQ Neurology
BR Eye

49 Hospital - Room and Board	95 Podiatry - Nursing Home Visits	BS Invasive Procedures
50 Hospital - Outpatient	96 Professional (Physician)	
51 Hospital - Emergency Accident	97 Anesthesiologist	

What would we do if **both** provider type and service type are sent???

2.2.3 Categorical Response

We will respond as documented in section 2.1.2, for the general response.

If the client is not covered for the type of service requested, we DO/DO NOT??? send information about eligibility for other service types. We send all the same data we would send for a general request.

2.3 Specific Request

[Same as 'General', plus …]

270-Request Contains:	HIPAA Data Element	MMIS supports	MHD supports
Procedure Code --or--	Loop 2110C EQ02	Y	Y
Diagnosis Code	Loop 2110C "BK" or "BF" III02	N	
Client DOB (optional)	Compare with proc age range		

In a "specific request" the requester is asking whether a client is covered for a specific procedure or diagnosis. If an Administration is currently answering eligibility inquiries at the service line level for a program, then HIPAA requires us to support the specific request based on procedures.

It must be decided for which programs we will respond to a specific request based on:

- Procedure?
- Diagnosis?

2.3.1 Procedure

We will need to add tables and logic for determining whether a client is covered for a certain procedure.

If a procedure is covered only if a certain diagnosis occurs, we send that diagnosis in the response.

How do we answer a specific services inquiry when:

1. the program uses the social services model? We would need (real-time or nightly?) updates of what services have been authorized for which clients.
2. the program uses the medical model? …

Shall we also determine whether there is a prior authorization number?

We shouldn't support responding Y/N regarding a procedure without checking the history of what's already used (limitation audits of prior usage). This would require keeping a count of usage for each client's procedures, based on claims adjudicated. A summary process could read the claims history file periodically to update this.

2.3.2 Diagnosis

Shall we support requests based on a specified diagnosis? Or just report crtain non-allowable diagnoses when relevant?

The EE TAG recommends NOT supporting inquiries based on diagnosis.

2.3.3 Specific Response

271-Response Contains:	HIPAA Data Element	MMIS
Procedure Code	Loop 2110D EQ013	PROCEDURE-MASTER: PROC-CODE
Diagnosis Code	Loop 2110D "BK" or "BF" III02	DIAGNOSIS-MASTER: DIAG-CODE-ICD-9
Procedure Coverage Max. Units	Loop 2110D EB07 where EB06="32"-Lifetime	PROCEDURE-MASTER: LIFETIME-SERVICE-IN indicates to check lifetime proc file for units?
Co-pay Amounts	Loop 2110D EB07 where EB01="B"-Co-Payment	PROCEDURE-MASTER: COPAYMENT-INDICATOR (just Y/N) add amount
Age Range	Loop 2110D EB10 where EB09="S7"-High Age and "S8"-Low Age (two EB segments)	PROCEDURE/DIAGNOSIS-MASTER: MINIMUM-AGE and MAXIMUM-AGE
Whether Prior Auth. Is Required	Loop 2110D EQ11 = Y/N	PROCEDURE/DIAGNOSIS -MASTER: PRIOR-AUTH-IND
Prior Auth Number, if obtained	Loop 2110D "G1" REF02	PRIOR-AUTHORIZATION: PRIOR-AUTH-NUM
Units Authorized	Loop 2110D EB10 where EB09="QA"-quantity approved	PRIOR-AUTHORIZATION: PA-UNITS-APPROVED
Units Used to Date	Loop 2110D EB10 where EB09="99"-quantity used	PRIOR-AUTHORIZATION: ?
Amount Remaining	Loop 2110D EB07 where EB06="29"-remaining	compute PRIOR-AUTHORIZATION: PA-AMOUNT-APPROVED minus PA-AMOUNT-USED

If we decide NOT to respond with procedure code level detail, we can respond with the relevant service type or provider type information instead.

3 Client Searching

HIPAA says that if a requester sends the following fields, we are required to respond. We can't require any further fields.

- Client last name
- Client first name
- Member ID
- Date of Birth

We will assume that if we have a PIC, we can identify the client, without needing to use any other validation logic. PIC is the DSHS-wide Medicaid ID, which is the primary ID in MMIS. There are other "Member IDs", depending upon system, e.g., ACES, SSPS, etc. HIC is HCFA's Medicare ID.

In the absence of a PIC number, we must be able to do a client search using some/any combination of the following (or other) fields to find a client.

For each of the below searches, we will respond if we find 1 and only 1 match. If we find zero or multiple matches, we will return an error.

Choose which of these searches to support for each program:

Search Type	Last Name	First Name	DoB	PIC	SSN	HIC	ACES ID	SSPS AUID	Other Program ID			Gender
State Medicaid Manual: 2 of name, DOB, SSN	Exact	Exact	Exact		Exact							
PIC				Exact								
Minimum	Exact	Exact	Exact									
HCFA (Medicare)	1st 5	1st 1	Exact			Exact						
ACES							Exact					
Program ID			Exact						Exact			

MEV "S"SN			Exact		Exact							
MEV "N"ame	Exact	Exact			Exact							
MEV "H"IC						Exact						
Client registry: 2 of 3	Exact	Exact	Exact		Exact							
CSDB: weighted match (see section 4.1)	5.0	6.1	6.0		8.2		14.1	4.0				

CSDB

CSDB is the Client Services Database developed by Research and Data Analysis (see Fred Fiedler) for needs assessment statistics. It uses an exact search on name, not a phonetic search. It allows different fields to be configured for use in matching. A weight is assigned to each field, depending on how likely a match on that field is to indicate that the data is about the same person. We could add PIC to the weighted fields and assign it a "heavy" weight. Regulations may prohibit capturing SSN, so if it is used, it should probably carry a "lighter" weight.

A threshold match weight is configured, which determines which matches are automatically treated as the same person. For example, if the threshold weight is 14.0 and fields have the weights shown in the previous table, then:

- an ACES ID match alone counts as the same person (14.1)
- a match on SSN and First Name counts as the same person (8.2 + 6.1 = 14.3)
- a match on SSN and DOB counts as the same person (8.2 + 6.0 = 14.2)
- a match on SSPS AUID, DOB and Last Name counts as the same person (4.0 + 6.0 + 5.0 = 15.0)
- etc.

It is currently updated only monthly, but they are interested in real-time or daily updates.

There are several options for leveraging this approach (not mutually exclusive):

1. Improve the CSDB with more data more frequently:
    a. get feeds from more program and more frequently
    b. send MMIS nightly extracts with program changes & authorized services to CSDB to make it more current

2. Receive an extract from the CSDB to use as a master client index with its cross-reference of IDs from multiple programs, using this to identify duplicates periodically (nightly or monthly?).
3. Clone the logic and use it independently in our own solution. It's in PL/SQL on an Oracle DB.

It was noted that client information coming from providers is less reliable than information received by CSDB.

4 MMIS Data versus ACES Data

MMIS has history data, that is, eligibility information prior to the current month, but ACES does not.

ACES can change what's authorized retroactively, and these changes are sent to MMIS in the extract file.

4.1 Which Fields are in MMIS and/or ACES

Data Element	MMIS has?	ACES has?	Send in 271?
lifetime units	Y	N	
Remaining = computed pa-amount-approved minus pa-amount-used	Y	N	
co-pay amount	Y	N	
valid min & max age for a proc or diag	Y	N	
pa-units-approved	Y	N	
units-used	Y	N	
prior auth indicator	Y	N	
TPL policy number	Y	Y	*
TPL subscriber name and ID	Y	Y	*
TPL membership number	Y	Y	*
TPL group number	Y	Y	*
TPL policyholder name	Y	Y	*
TPL coverage begin/end dates	Y	Y	*
TPL carrier name and internal ID	Y	Y	Y
Medicare Buy-In Number Code	Y	Y	Y

Medicare Part A and B Buy-In Elig Date	Y	Y	N
Medicare Part A and B Buy-In premium Date	Y	Y	N
Medicare Part A and B Buy-In Premium Amount	Y	Y	N
Medicare Part A and B Buy-InEligibility Code	Y	Y	N
Restricted Recipient Info: DD, hospice, children with special needs (EB05 plan coverage description)	Y	Y	Y
Restricted to provider (EB01="N" and NM101="13")	Y	N	Y
Managed healthcare info (HMO=PCOP) (EB01="1" with EB04="MC; and EB01="1" with EB04="HM" and NM101="1P")	Y	Y	Y
ITA-blind-ind (III02 diagnosis)	Y	N	N
Medical ID Card (MAID) info that isn't in ACES (CSO generated MAIDs)	Y	N	Y
Client's Nursing Home Info (No place to go in HIPAA 271)	Y	N	Y
Spenddown amounts, period start, remaining (add to extract for MHD)	N	Y	Y

* During EE TAG discussion 9/25, these fields were thought to be inaccurate. But when I discussed using these for electronic COB with Carmen Gigstead, she said they are verified. This needs to be clarified. See section 2.1.3.

4.2 ACES Data That Has No Place To Go in HIPAA 271

These were discussed and thought to not be a problem that we can't send them.

1. AU total number in family
2. Client race (Native American code, Spanish Hispanic Origin Code) (DMG "race" is not used)
3. Client Alien Indicator (DMG "citizenship" is not used)
4. Client Primary Language Indicator (can send it in 834-enroll [LUI], not 271)
5. Client Pregnancy Due Date
6. Client Closing Reason Code
7. Client's Number of Eligibility Spans (can send it in 834-enroll [loop 2000 REF "QQ"], not 271)
8. HOH name and ID

5 Future Functions

5.1 Batch

Currently only realtime support for single 270/271 inquiries is being planned. If batch support is requested, it will be considered later. This means that we are planning to support only transactions inquiring about one information source (us), one requester, one client, one specific service type –or– service/procedure.

5.2 Other Actions

With a specific request, we have the option of someday supporting the following actions:

1. To support sending Prior Auth data, search PA file for matching PA.
2. Provider sends amount to deduct from client's remaining spend down amount, and we deduct it. [BHT06 & loop 2110C AMT "R"-spend down amt] [need to get spend down amt from ACES]
3. Provider sends number of services used to deduct from client's remaining number of services authorized, and we deduct it. [BHT06 & loop 2110C AMT "R"-spend down amt]

6 Configure Eligibility Options for Each Program

Each program will decide how an eligibility request will be answered. Using the above document, indicate your decisions below.

6.1 Requester Access

Determine whether a Requester must be:
- Registered for eligibility requests, that is, Active in the permission file?
- Allowed access to the program(s) being inquired about?
- Allowed access to the service type(s) being inquired about?
- Under the maximum number of requests per day per requester set up for each program?
- What is the maximum number of requests per day per requester?

6.2 Categorical Response

Using a copy of Section 2.1.2 above, decide whether each of the data fields list should or should not be sent when responding with information about the program.

6.3 Support Specific Response

Will data be stored centrally in MMIS/EEDB about a client's specific authorized services?

6.4 Client Searching

Using the types of searching listed in Section 4, indicate which search options should result in a response with the program level information.